SUMMARY OF INCIDENTS FOR FIRST QUARTER 1999

I-7403 - Misadministration - University Medical Center - Lubbock, Texas

On December 31, 1998, the Registrant notified the Agency of a misadministration involving the wrong treatment site on a patient undergoing [redacted] that occurred on December 16, 1998. A photon beam linear accelerator was involved. The event occurred because the upper border of the field was not identified on the computed tomography (CT) scan. The patient [redacted]. A dose of [redacted]. The prescribing physician was immediately notified and the referring physician was notified within 24 hours. [redacted] To prevent a recurrence, an enlarged CT image of a patient will be placed on the front page of a patient's chart. The image will display the treatment area in color with relation to a setup point. In addition a port film will be taken of the setup region before the first treatment and compared to the reconstructed image from the treatment planning computer to ensure an accurate setup. Both films will be reviewed and signed by the treating physician prior to treatment.

File Closed.

I-7404 - Overexposure - Global X-Ray & Testing Corporation - Houston, Texas

On January 1, 1999, the Licensee notified the Agency of a 10 rem whole body and a 5000 rem extremity exposure to a radiography trainee on December 31, 1998. The Licensee sent a radiographer and a trainee to a job site and neither was aware the they did not meet the requirements of a radiography crew. After setting up to radiograph a three inch piece of pipe the trainee discovered he had not cranked the source into the shielded position after a previous shot and had been exposed. The Licensee was cited for: failure to control the occupational exposure to an individual; allowing a radiographer trainee to manipulate the controls of a radiographic exposure device without being under the direct supervision of a radiographer trainer; failure to perform a radiation survey after each radiographic exposure to determine that the sealed source had been returned to its fully-shielded position; allowing radiographic operations without a minimum of two radiographers or a radiographer trainer and radiographer trainee or

radiographer; and allowing a radiographer trainee to perform radiographic operations without wearing an alarming rate meter or a thermoluminescent dosimeter. The Licensee was referred for escalated enforcement.

File Closed.

I-7405 - Stolen Radioactive Material - Buster Paving Company, Inc. - Sulphur Springs, Texas

On January 4, 1999, the Licensee notified the Agency that a moisture density gauge containing an 8.0 millicurie cesium-137 source and a 40 millicurie americium-241 source had been stolen on a weekend from the company field laboratory. Local police were notified of the burglary. The Licensee ran radio and newspaper announcements for thirty days to alert the public and to seek the return of the gauge. In an effort to prevent further thefts, the Licensee installed burglar bars on the windows and a barricade bar on the door. The gauge has not been recovered.

File Inactive.

I-7406 - Radioactive Material at a Landfill - Gulf Coast Veterinary Specialists/BFI - Houston, Texas

On December 14, 1998, the Agency was notified that a garbage truck activated the radiation alarm at a landfill. An initial investigation did not detect radiation levels above background. After the landfill detectors were activated by the same load on the following day a detailed survey of the entire load located two small plastic bags, each with radiation readings of two millirems per hour on contact. The investigation determined the bags contained contaminated cat litter. On December 4, 1998, a cat had been hospitalized at a veterinary facility and administered a 4.5 millicurie dose of iodine-131 for treatment of hyperthyroidism. On December 9, 1998, the cat was surveyed as required, radiation levels met the Licensee's authorized release limits, and the cat was sent home. The contaminated cat litter came from the cat owner's home. To prevent a recurrence, the veterinary facility will modify instructions to owners of cats that have similar treatments to store the litter for radioactive decay before disposing in the regular trash. No violation of license conditions was noted.

File Closed.

I-7407 - Radioactive Material at a Scrapyard - MQS Inspections

Incorporated - Houston, Texas

On December 22, 1998, the Agency was notified that a crate of contaminated scrap had activated the radiation alarm at a scrapyard and was returned to the Licensee. A piece-by-piece survey of the crate located an old depleted uranium collimator from a cobalt-60 exposure device. The Licensee did not know where the collimator came from. The Agency instructed the Licensee to add the device to their radioactive material inventory for accountability.

File Closed.

I-7408 - Dose Irregularity - Saint Luke's Episcopal Hospital/Syncor International Corporation - Houston, Texas

On December 23, 1998, the Licensee notified the Agency of an irregularity in the receipt of radiopharmaceuticals delivered to the hospital by the nuclear pharmacy. Instead of receiving a 200 microcurie capsule of iodine-123, the hospital received a 200 millicurie capsule of technetium-99m sodium pertechnetate addressed to another facility. The hospital notified the pharmacy of the misdelivered radioactive material. The pharmacy then delivered the correct shipment and the misdelivered shipment was retrieved for delivery to the correct address.

File Closed.

I-7409 - Badge Overexposure - Columbia Conroe Regional Cancer Center - Conroe, Texas

On January 11, 1999, the Registrant notified the Agency of 2.30 and 2.66 rem exposures to a therapist during the 09/20/98 - 10/19/98 and 10/20/98 - 11/19/98 monitoring periods, respectively. The Licensee determined the therapist inadvertently dropped both badges in a linear accelerator treatment room. On the first occasion the badge was found near a rack of therapy blocks in a treatment room after approximately one and one half days. On the second occasion the badge was found on the floor of a treatment room. The therapist is petite and the Licensee believes the badge was pulled from the therapist's clothing as she reached over the therapy blocks. The therapist indicated the badge frequently became dislodged during positioning of patients or when it was necessary to stretch across items and equipment. The employee was counseled and instructed by the Licensee to be more careful and attentive of the badges. To prevent the dislodging of the badge, the

therapist places the badge in a special pouch provided by the facility that is worn anchored underneath the therapist's garments near the neck area. A deletion was allowed and a minimal assessment, based on past average exposures, was accepted for each month.

File Closed.

I-7410 - Overexposure - Technical Welding Laboratory, Inc. - Pasadena, Texas

On January 14, 1999, the Licensee notified the Agency of a 5.2 rem whole body exposure to a radiographer during the 1998 monitoring period. The radiographer lost his personnel monitoring badge on four occasions. The Licensee assessed exposures to the radiographer for the February, June, July, and November 1998 monitoring periods. The Licensee failed to notice that the badge processing company had not added the July 1998 assessed exposure to the badge report exposure history as had been requested. Unaware that the radiographer's total exposure was close to exceeding the annual exposure limit, the Licensee allowed the radiographer to continue performing radiography throughout the final monitoring period of the year. The Licensee indicated the dosimetry service had temporarily misplaced the letter requesting an amended exposure report. The badge company posted the July 1998 assessment to an exposure report dated December 22, 1998. The Licensee received the report in January of 1999. The Licensee was cited for allowing an individual to receive an exposure greater than the annual regulatory limit. To prevent a recurrence of dose assessments not being posted to an employee's monitoring record the Licensee will send dose assessment letters by facsimile to the dosimetry service, will follow-up by mailing the hardcopy, and then make telephonic contact to ensure timely posting to exposure records. The records will be reviewed to ensure exposures do not exceed the limits.

File Closed.

I-7411 - Overexposure - Technical Welding Laboratory, Inc. - Pasadena, Texas

On January 21, 1999, the Licensee notified the Agency of a 5.5 rem whole body exposure to a radiographer trainer during the 1998 monitoring period. The radiographer received a whole body exposure of 4.560 rem during the December 1, 1998 through December 31, 1998, monitoring period. The Licensee's request for a deletion of the 4.560 rem exposure, based on pocket dosimetry records indicating 220 millirems of exposure for the same period, was denied. An Agency investigation determined the facts were not sufficient to allow the deletion. The Licensee was cited for failure to control the occupational dose.

File Closed.

I-7412 - Overexposure - H & G Inspections, Inc. - Houston, Texas

On January 8, 1999, the Licensee notified the Agency of a 5.53 rem whole body exposure to a radiographer during the 1998 monitoring period. Initially the result of the December badge evaluation was not available as it had not been returned by the dosimetry service. When the badge was evaluated, 130 millirems was added to the radiographers exposure history, bringing his annual exposure to 5.53 rem. The Licensee was cited for allowing an individual to receive an exposure greater than the regulatory annual limit. The Licensee cited a delay in getting results from the dosimetry company as a reason for not suspending the radiographer from duties involving radiation exposure during the months of November and December. The Licensee assigned the radiographer to duties involving more film processing and very little radiography in an effort to minimize the radiographer's future exposure.

File Closed.

I-7413 - Equipment Damaged - Team Consultants, Inc. - Dallas, Texas

On January 26, 1999, the Licensee notified the Agency of a traffic accident which occurred December 30, 1998, involving a moisture density gauge containing a 5.2 millicurie cesium-137 source and a 38.7 millicurie americium-241 source. The vehicle overturned, damaging the plastic case holding the gauge. The gauge was visually inspected on-site, appeared un-damaged, and was returned to storage. A leak test performed on the gauge December 31, 1998, confirmed no leakage. The storage case for the gauge was replaced and the gauge was returned to service.

File Closed.

I-7414 - Badge Overexposure - University of Texas Health Science Center Houston - Houston, Texas

On January 4, 1999, the Licensee notified the Agency of a 22.80 rem exposure to the eye of an employee during the November 1998 monitoring period. An Agency investigation determined the employee works as an electrical engineer performing daily alignment of cyclotron beams prior to activation. The eye lens dosimeter was attached to the engineer's goggles which were worn while he was performing daily maintenance inside the vault. The engineer removed the goggles and inadvertently left them inside the vault. The dosimetry was exposed to a scattered beam for a period of 36 hours while production emitters was in progress. The interlocks would not allow the engineer to reenter the vault to retrieve the glasses until after radiation levels were below 25 millirem per hour. A deletion was allowed and an assessment of 0.320 rem, based on the eye lens monitoring reports for two other employees performing similar job functions during the same period, was accepted. The Licensee was cited for allowing an employee to work in an area near the cyclotron while not wearing an assigned personnel monitoring device.

File Closed.

I-7415 - Laser Incident - 3M - Austin, Texas

On January 22, 1999, the Registrant notified the Agency of a laser incident which illuminated the face of an employee on January 13, 1999. The exposure occurred in a controlled area and involved a 248 nanometer laser operating in the pulsed mode firing 500 milliJoule pulses at 50 pulses per second. The employee, wearing appropriate laser safety eyewear, was standing and observing the machine in operation, and was exposed above a polycarbonate shield. The shield was designed to prevent direct or scattered exposure to seated observers. The exposed employee noticed slight redness to the side of his face several hours after the exposure. The following day, the employee's skin had returned to normal. The facility had additional shielding on order at the time of the incident that would protect standing observers. In addition, the facility has ordered additional personal protection equipment in the form of ultraviolet opaque face shields.

File Closed.

I-7416 - Loss of Radioactive Material - Sperry-Sun Drilling Services / Federal Express - Houston, Texas

On January 12, 1999, the Licensee notified the Nuclear Regulatory Commission (NRC) that a 2 curie (74 gigabecquerel), cesium-137 well logging source was lost during shipment on November 30, 1998. The NRC notified the Agency on January 12, 1999, of the loss. The source was shipped by Federal Express (FedEx) from Houston, Texas and was not received by the Licensee's facility in Alaska. The source was located in Singapore and recovered by FedEx on February 24, 1999. It was then returned to the Houston Licensee on February 25, 1999.

File Closed.

I-7417 - Dose Irregularity - Amarillo Diagnostic Clinic - Amarillo, Texas

On January 6, 1999, the Licensee notified the Agency of an irregularity that occurred on December 17, 1998. A patient was scheduled to receive [redacted] for a [redacted]. Since this was the first [redacted] ever ordered at the clinic, the appointments staff [redacted]. The patient was [redacted]. The patient, referring physician, and R.S.O. were all immediately notified. The whole body dose was less than 5 rem and the dose to any organ did not exceed 50 rad. The [redacted] was successfully completed at a later date. To prevent a recurrence the Licensee met with the appointments supervisors to ensure scans of that type are ordered correctly in the future and nuclear medicine technologists were instructed to double check the physicians orders before scans are initiated, instead of relying on the schedule from the facility's appointment calendar.

File Closed.

I-7418 - Dose Irregularity - The University of Texas, M.D. Anderson Cancer Center / Mallinckrodt - Houston, Texas

On January 22, 1999, the Licensee notified the Agency of a mis-labeled radiopharmaceutical container received at the hospital on January 10, 1999. The radiopharmacy had ordered a dose of technetium-99m MAA. When the dose arrived at the facility the outer container was mis-labeled technetium-99m TcO_4, even though the dose inside the container was correctly labeled technetium-99m MAA. The manufacturer was notified and sent a

representative to the facility to apply the correct label to the mis-labeled container. The study was successfully completed.

File Closed.

I-7419 - Source Abandoned Downhole - Halliburton Energy Services - Houston, Texas

On February 4, 1999, the Licensee notified the Agency that a 1.5 millicurie cesium-137 source had been abandoned downhole at a depth of 10,200 feet on February 2, 1999. The tool with the source became stuck on February 2, 1999, and attempts to retrieve the source were unsuccessful. The source was abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation 25 TAC §289.253.

File Closed.

I-7420 - Laser Exposure - 3M, Austin - Texas

On February 15, 1999, the Registrant notified the Agency of an incident involving direct laser exposure to the unprotected skin of an operator during setup and alignment of the beam path. The exposure occurred in a controlled area and involved a 248 nanometer laser operated in the pulsed mode, firing 200 milliJoule pulses at 50 pulses per second. The operator was exposed while checking the beam path alignment. A mirror was misaligned and the ploycarbonate shielding was removed in order to gain access to the optics. The employee did not follow designated safety procedures and was exposed on his forearm, causing a slight reddening of the skin. To prevent reoccurrences, laser operators in this area of the company were re-trained on the appropriate use of protective enclosures and personal protective equipment on February 10, 1999. The Registrant was cited for violations.

File Closed.

I-7421 - Stolen Radioactive Materials - Schlumberger Oilfield Services - Sugar Land, Texas

On February 23, 1999, the Licensee notified the Agency that a truck containing 1.4 millicuries of depleted uranium and two cesium-137 sources, each less than 100 microcuries, was stolen in Sonora, Texas. The truck with all radioactive material was recovered on February 26, 1999, and the sources were undamaged.

File Closed.

I-7422 - Well Logging Source Abandoned Downhole - Schlumberger - Sugar Land, Texas

On January 31, 1999, the Licensee notified the Agency that a 1.7 curie cesium-137 source had been abandoned downhole at 7818 feet. Repeated attempts to recover the source were unsuccessful. The source was abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25 TAC §289.253.

File Closed.

I-7423 - Equipment Damage - Trinity Engineering Testing Corporation - Corpus Christi, Texas

During an inspection of the Licensee's facility on February 11, 1999, an Agency inspector noted that a moisture density gauge containing an 8 millicurie cesium-137 source and a 40 millicurie amercium-241 source had been damaged during a vehicle accident and fire on May 2, 1998. The vehicle was taken to a vehicle impound lot and the gauge was recovered from the melted plastic transport case. Leak tests indicated radioactive material leakage and the gauge was returned to the manufacturer for disposal.

File Closed.

I-7424 - Equipment Damage - Geoscience Engineering and Testing, Inc. - Dallas, Texas

On March 1, 1999, the Licensee notified the Agency that a moisture density gauge containing a 40 millicurie americium-241 source and an 8 millicurie cesium-137 source had been damaged on February 19, 1999. The gauge was damaged when a company operated backhoe inadvertently backed over the unattended gauge. Both sources were undamaged. The company held a safety meeting on February 22, 1999, which emphasized safety for nuclear gauges when the gauges were in the possession of authorized technicians. The company was cited for allowing unauthorized access to the gauge.

File Closed.

I-7425 - Dose Irregularity - Syncor Pharmacy Services / Kelsey-Sebold Clinic - Houston, Texas

On March 1, 1999, the Licensee notified the Agency of a dose irregularity which occurred February 26, 1999, involving a dose of [redacted]. [redacted]. A subsequent quality control test on the vial of [redacted] from which the prescription had been drawn, showed a [redacted] versus the initial [redacted]. The syringe was returned to the pharmacy for examination of the residue. The residue resulted in a [redacted]. The material from the syringe passed two additional quality control tests. Syncor's analysis of the residue remaining in the returned syringe indicated the [redacted]. Tests to determine if other drugs the patient was taking may have interfered with uptake [redacted]. The prescribing physician was notified.

File Closed.

I-7426 - Dose Irregularity - Syncor Pharmacy Services / Baptist Medical Center - San Antonio, Texas

On March 3, 1999, the Licensee notified the Agency of a possible dose irregularity. A prescription for [redacted] Subsequent scans were consistent with [redacted] A quality control analysis revealed that in fact [redacted]. To avoid future incidents all pharmacists and dispensing personnel have been trained on procedures to prevent dose irregularities, which include visually checking the prescription before filling and ensuring that only one vial is in the dispensing hood at the time a prescription is filled.

File Closed.

I-7427 - Badge Overexposure - River Oaks Imaging - Houston, Texas

On March 5, 1999, the Registrant notified the Agency of a 5.45 rem exposure to a physician for the 1998 monitoring period. The Registrant was unaware of the exposure until a change in personnel responsible for reviewing and maintaining radiation exposure information took place at the facility. Because the physician performed numerous procedures using fluoroscopy and C-Arm equipment, he wore two personnel monitoring badges. One badge, worn at the neck outside a protective apron, received 5.45 rem. A second badge, worn at the waist underneath the protective apron, received 1.31 rem. Based on a regulatory formula, the exposure assigned was the sum of the exposure to the waist badge multiplied by 1.5 and the exposure to the neck badge multiplied by 0.04, that is [(1.31 x 1.5) + (5.45 x 0.04) = (1.965 +0.218) = 2.183]. Using the formula, the doctor was assessed a calculated annual whole body exposure of 2.183 rem. The facility counseled the physician to apply ALARA principles while performing fluoroscopic procedures.

File Closed.

I-7428 - Overexposure - H & G Inspection Company - Houston, Texas

On March 12, 1999, the licensee notified the Agency of a 5.400 rem whole body exposure for the 1998 monitoring period. 3.53 rem of the exposure occurred during the December 1998 monitoring period. The Licensee was unable to determine the cause of the exposure. The employee stated he had not misplaced his badge during the December monitoring period and his pocket dosimeter readings totaled 0.212 rem. The employee had been performing radiography in a shielded bay facility during the December monitoring period. The Licensee was cited for the violation.

File Closed.

I-7429 - Overexposure - H & G Inspection Company - Houston, Texas

On March 12, 1999, the licensee notified the Agency of a 5.18 rem whole body exposure for the 1998 monitoring period. 1.260 rem of the exposure occurred during the December 1998 monitoring period. The Licensee was unable to determine the cause of the exposure. The employee stated he had not misplaced his badge

during the December monitoring period and his pocket dosimeter readings totaled 0.670 rem. The employee had been performing radiography at fabrication shops and plants without using shielding bays and also conducted radiography on a pipeline out of state. The Licensee was cited for the violations.

File Closed.

I-7430 - Badge Overexposure - The University of Texas, Southwestern Medical Center - Dallas, Texas

On March 8 ,1999, the Registrant notified the Agency of 3.08 rem and 2.84 rem exposures for the June 1998 and July 1998 monitoring periods respectively. The film badge supplier reported the exposures were to high energy radiation while the employee only worked with low energy radiation. A deletion was allowed and a 100 millirem assessment, based on low energy exposures, was accepted for each month.

File Closed.

I-7431 - Stolen Radioactive Materials - TEAM Consultants, Inc. - Dallas, Texas

On March 22, 1999, the Licensee notified the Agency that a moisture density gauge containing a 40 millicurie americium-241 source and an 8 millicurie cesium-137 source was stolen from an operator's vehicle while parked overnight at his residence on March 19, 1999. The Licensee notified local police and fire departments, Troxler Electronics, and Richardson and Associates of the theft. Information concerning the stolen gauge was posted to all Troxler facilities. In order to prevent recurrence of the theft, storage and use procedures have been reviewed, a new Daily Use Log has been implemented in order to determine that the gauges are properly stored each day, and all gauge users have been individually counseled by the Radiation Safety Officer on the importance of proper storage. The gauge has not been recovered. The Licensee was cited for not securing the gauge.

File Inactive.

I-7432 - Dose Irregularity - Park Plaza Hospital - Houston, Texas

On March 15, 1999, the Licensee notified the Agency that a nuclear medicine technologist had injected the wrong patient with [redacted] The technologist did not verify the patient's identity. The referring physician and patient were notified. The Nuclear Medicine staff has been in-serviced regarding the necessity of verifying all patient's identities before injecting any nuclear medicine in accordance with safety policy and procedure.

File Closed.

I-7433 - Equipment Damaged - Rhodes Testing - Longview, Texas

On March 23, 1999, the Licensee notified the Agency that a density gauge containing an 8 millicurie cesium-137 source was damaged when an eighteen wheeler swerved between orange safety cones marking the working location. The damaged gauge had the source in the locked position at the time of the incident and no leakage was detected. The transport case and gauge were returned to the manufacturer the same day for repair or disposal.

File Closed.

I-7434 - Leaking Source - Southwest Research Institute - San Antonio, Texas

On March 18, 1999, the Licensee notified the Agency that a stored Electron Capture Device (ECD) was wipe tested with the resulting analysis of 0.008 µCi of activity, in excess of the 0.005 µCi limit. The ECD was removed from storage on March 19, 1999, triple bagged, and taken to the Radiation Effects Facility to await disposal along with other radioactive waste and another surplus ECD that will be disposed of at a licensed disposal site.

File Closed.

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COMPLAINT SUMMARY FOR FIRST QUARTER 1999

C-1365 - Regulation Violations - Jo Ann Thiel, D.D.S. - The Colony, Texas

On January 4, 1999, the Agency received a complaint alleging that the Registrant allowed untrained and uncredentialed individuals to perform radiographs. The complainant further alleged that employees of the facility were not allowed to access or review relevant sections of radiation control regulations and operating and safety procedures. An Agency investigation determined an uncredentialed individual performed radiographs. Information regarding the individual's lack of credentialing was forwarded to the Texas State Dental Board for compliance actions. Radiation regulations and operating and safety procedures were available to the employees and employee signatures attested to them having read the documents. The Registrant was cited for Agency regulation violations.

File Closed.

C-1366 - Regulations Violations - San Antonio Diagnostic Imaging, Inc. - San Antonio, Texas

On February 4, 1999, the Agency received an anonymous complaint alleging that the Registrant was not maintaining quality control in keeping with mammography regulations which led to fogged film. An agency investigation determined the Registrant failed to perform daily processor performance evaluation on November, 24, 1998, a day on which mammograms were performed. The Registrant also failed to analyze the processor performance daily evaluation, a daily quality control item, during the periods of January 18 through 22, 1999, and January 25 through 29, 1999. The Registrant was cited for the violations. The Agency was unable to substantiate the occurrence of fogged films.

File Closed.

C-1367 - Regulation Violation - Tomball Regional Hospital - Tomball, Texas

On January 4, 1999, the Agency received a complaint alleging that gonadal shielding was not provided during a series of medical radiographs. On February 18, 1998, 13 radiographs were performed on the complainant. The complainant stated that a technologist had initially said lead shielding would be used. However, upon performance of the procedure, the use of shielding was denied. An Agency investigation determined that the Registrant had denied the complainant use of lead shielding due to possible interference or obstruction to the views required on the films. The Registrant stated that the technologist told the complainant the radiographic beam would be coned down to the area of interest to reduce exposure. No violations were cited.

File Closed.

C-1368 - Exposure to Member of the General Public - Non-Destructive Inspection Corporation - Clute, Texas

On January 6, 1999, the Agency received a complaint from the Nuclear Regulatory Commission alleging that on November 25, 1998, industrial radiographers did not control access to an area where radiography was performed, barriers were not in place, and a survey instrument was not used. An Agency investigation was unable to substantiate the allegations. The radiographers claimed to have been finished for the day and was in the process of dismantling barriers and equipment when the complainant visited their work site. No violations were cited.

File Closed.

C-1369 - Uncredentialed Technologist - Rodriguez Dental Services - Killeen, Texas

On January 25, 1999, the Agency received an anonymous complaint alleging that a Registrant allowed uncredentialed technologists to perform radiographs on dental patients. The complainant further alleged that on three separate occasions an uncredentialed technologist had inadvertently exposed other technologists and patients to radiation. Allegedly, the technologist pushed the wrong button on a control panel and energized the beam in the wrong room. An Agency investigation determined that three persons performed x-ray examinations on patients prior to receiving credentials from the State Board of Dental Examiners. The complaint and Agency findings were referred to the State Board of Dental Examiners for actions

deemed necessary. The Registrant was cited for Agency violations.

File Closed.

C-1370 - Uncredentialed Technologist - Columbia St. David's Healthcare (South Austin Hospital) - Austin, Texas

On January 25, 1999, the Agency received an anonymous complaint alleging that the Registrant allowed uncredentialed technologists to perform radiographs, including fluoroscopy, special procedures, emergency room and operating room x-ray procedures. An Agency investigation determined the technologist was not credentialed. The Registrant was cited for the violation.

File Closed.

C-1371 - Uncredentialed Technologist - Colorado Fayette Medical Center - Wiemar, Texas

On January 1999, the Agency received an anonymous complaint alleging that an uncredentialed technologist was performing mammographic procedures during the absence of the Registrant's credentialed technologist. An Agency investigation confirmed that an uncredentialed technologist performed mammography from December 22, 1998, to January 11, 1999, and on January 25, 1999. The Registrant was cited for five additional violations related to the production of timely, quality mammograms. The Registrant was referred for escalated enforcement.

File Closed.

C-1372 - Regulations Violation - Panhandle NDT and Inspection Company - Borger, Texas

On January 27, 1999, the Agency received a complaint alleging that the Licensee was: falsifying daily job records by allowing personnel to use radiation badges of other employees; allowing personnel to work as radiographers without the required 40 hour radiation safety training course; failing to inform new employees of the Licensee's operating and emergency procedures and requiring new employees to wear radiation badges assigned to other employees. An Agency inspection substantiated the alleged violations against the Licensee. The Licensee was cited for the violations. An Enforcement Conference was also conducted with

the Licensee. Information was received from the Nuclear Regulatory Commission listing violations similar to those noted by the Agency which were alleged to have occurred in Texas and Kansas.

File Closed.

C-1373 - Regulation Violation - Nutritional Biomedicine - Plainview, Texas

On February 16, 1999, the Agency received a complaint referred from the Texas Department of Health's Medical Radiologic Technologist Certification Program and the Texas State Board of Medical Examiners alleging that an individual used a bone densitometry unit to perform radiographic scans on patients and interpreted the radiographs without a physician's involvement. The complainant further alleged the individual: was not credentialed to operate the unit as required; performed screening on individuals who did not meet the authorized screening criteria; applied radiation for demonstration purposes; and failed to notify the Agency of a change in radiation safety officer within 30 days of the change. An Agency investigation determined the equipment was sent to the manufacturer for repair on December 1, 1998. The operator indicated that there are no plans to resume use of the equipment unless proper operator credentialing and a licensed practioner can be secured by the Registrant. The allegations could not be substantiated.

File Closed.

C-1374 - Unauthorized Possession of Radioactive Materials - C.C. Rider - Willis, Texas

On March 11, 1999, the Agency received a complaint alleging that radioactive materials were stored in a residential area. These materials were alleged to be stored inside a shed in a large metal box and a 5-gallon container both labeled radioactive materials. The complainant further alleged that the materials have been in storage at the location for a period of 5-20 years and may present a hazard to the neighborhood. An Agency investigation determined that the containers were empty and radioactive markings were inappropriate for both containers. The markings were obliterated.

File Closed.

C-1375 - Regulation Violation - South Texas Medical Center - San Antonio, Texas

On March 29, 1999, the Agency received a complaint alleging that the Registrant performed a [redacted] on a teenager without a physician's order. An Agency investigation determined the referring physician ordered a [redacted] and did not order a [redacted]. The [redacted] was performed as requested and no

[redacted]. To obtain a complete evaluation and based on standard procedure, the Registrant's staff radiologist ordered a [redacted] to consist of one view. No violations were cited.

File Closed.

C-1376 - Regulation Violation - Wood Group Logging Services (Tri-Star Wireline, Inc) - Houston, Texas

On April 9, 1999, the Agency received a complaint alleging that on February 9, 1999, an employee was sent to log oil wells using a radioactive source without being provided with personnel monitoring. The complainant further alleged that a source had to be handled by hand without the use of a handling tool. An Agency investigation determined the logging company was not properly licensed for operation of a subsite in Edinburg, Texas. In addition, the company was cited for failure to conduct an adequate maintenance program in that a source handling tool was found to be incapable of screwing onto a source to perform a physical inventory during the agency investigation and the tool had not been removed from service, as required. Two sources in a downhole storage had no visible markings, serial numbers, or etchings. Transport containers were not labeled properly. Utilization records were incomplete. The company was cited for the violations.

File Closed.

C-1377 - Unauthorized Equipment Use - Bob J. Martin, DDS - Houston, Texas

On April 9, 1999, the Agency received a complaint alleging that the Registrant had moved his equipment from his authorized use location, to a new facility that was not registered with the state. An Agency investigation was unable to locate the Registrant and found no request for a change in authorized use locations. However the equipment is registered to the dentist who had removed the equipment and rules allow him 30 days to notify the Agency of a change in use location. The Agency's Registration Branch has been alerted to watch for the request for change in authorized use location and to notify Compliance and Inspection if a request for change has not been received within 30 days.

File Closed.

C-1378 - Uncredentialed Technologist - Orthopedic Surgery and Sports Medicine - Corpus Christi, Texas

On March 8, 1999, the Agency received an anonymous complaint alleging that the Registrant allowed an uncertified technologist to perform radiographs. An Agency investigation determined that the technologist in question was issued a temporary General Medical Radiologic Technologist Certificate in 1998. This certificate is valid until June 22, 1999.

File Closed.

C-1379 - Unregistered Equipment - Stephanie Kodack, M.D. - Austin, Texas

On February 11, 1999, the Agency received a complaint alleging the use of an unregistered portable bone densitometry unit. It was reported that this unit had been seen in the doctor's office since December 17, 1998. The allegation further stated the operator had not completed the required training to operate the machine. An application for registration was filed with the Agency on February 17, 1999, and the resulting Certificate of Registration was issued on March 4, 1999. The operator was in the process of obtaining the required training and credentials. An Agency inspection will be scheduled to document followup compliance.

File Closed.

C-1380 - Unauthorized Radioactive Material - Traders Village Flea Market - Grand Prairie, Texas

On March 31, 1999, the Agency received a complaint alleging that a radiography camera was in the possession of unlicensed individuals and being offered for sale to the general public at a flea market. An Agency inspector contacted the facility and was admitted on April 3, 1999. The inspector surveyed the entire complex. The camera was not located.

File Closed.

C-1381 - Unregistered Laser - Ridglea Theater - Fort Worth, Texas

On December 22, 1998, the Agency received an anonymous complaint alleging that the theater was operating an un-registered laser every Thursday and Friday evening during parties held at the theater. An Agency investigation verified there was an un-registered laser used at the location. The owner of the equipment was cited for the violation.

File Closed.

INCIDENTS CLOSED SINCE FOURTH QUARTER 1999

NO INCIDENTS WERE CLOSED SINCE FOURTH QUARTER 1999

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COMPLAINTS CLOSED SINCE FOURTH QUARTER 1999

NO INCIDENTS WERE CLOSED SINCE FOURTH QUARTER 1999

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES
REPORTED DURING THE FIRST QUARTER 1999

NO HOSPITAL OVEREXPOSURES WERE REPORTED FOR FIRST QUARTER 1999

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APPENDIX B

SUMMARY OF RADIOGRAPHER OVEREXPOSURES
REPORTED DURING THE FIRST QUARTER 1999

Houston, Texas

Global X-Ray & Testing Corporation
2
H & G Inspection Company
2

Pasadena, Texas

Technical Welding Laboratory, Inc.
2

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APPENDIX C

ENFORCEMENT ACTIONS FOR FIRST QUARTER 1999

Enforcement Conference: P.L.P.S., Inc. - Houston, Texas - Industrial Radiography

On January 26, 1999 an Enforcement Conference was held with the Licensee to discuss the violations found during an inspection performed at the Licensee's facility on October 6, 1998. The violations included the Licensee exceeding the authorized radioactive possession limits and other violations indicating a unacceptable deficiency with regard to the application and overall effectiveness of the radiation safety program. After reviewing the Licensee's response to these violations during the conference the Agency increased the Licensee's inspection frequency and required additional assistance for the RSO in order to maintain compliance with their radiation protection program. At the conclusion of the conference the Licensee requested a license amendment to increase their possession limits. All corrective actions were brought into compliance by February 1, 1999.

Enforcement Conference: Panhandle N.D.T. & Inspection, Inc. - Borger, Texas - Radiography

On March 26, 1999, an Enforcement Conference was held with the Licensee to discuss the violations found during a complaint investigation conducted on February 2, 1999 and the unacceptable defiencies in the application and overall effectiveness of the Licensee's radiation safety program. Violations included: failure to meet accurate and factual record requirements; allowing radiographic operations to be conducted at temporary job sites without as a minimum, two radiographers or alternatively, a radiographer trainer and a radiographer trainee; allowing personnel to act as radiographer trainees although these individuals did not have either a trainee status card or a copy of a completed TRC Form 31-1E on their persons; requiring personnel to wear personnel monitoring devices that had been assigned to other personnel; and failure to provide six employees with applicable sections of 25 T.A.C., license and agency approved operating, safety, and emergency procedures while acting as radiographic trainees, as well as verification that they could demonstrate sufficient understanding of them. As a result of the conference, the Licensee will: conduct, within sixty days of the date of the conference, a refresher

radiation safety course to all employees; provide an attendance list and topics of discussion to the Agency upon completion of the course; provide dose assessments for the six employees not furnished with personnel dosimetry. The Agency increased unannounced inspection frequencies and accessed administrative penalties.

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*****NOTE: Items within these summaries have been redacted (blackened out) due to confidential medical information under the Medical Practice Act and The Texas Public Information Act.**